

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

1. Inpatient Hospital Services

Except as otherwise specified in Attachment 3.1-E, Standards for the Coverage of Organ Transplant Services, up to 30 days of care during each Title XIX spell of illness are covered if medically necessary. The Title XIX spell of illness limitations are waived for medically necessary inpatient services provided to recipients less than age 21 to comply with the EPSDT provisions of the Omnibus Budget Reconciliation Act of 1989 and the provisions of Section 4604 of the Omnibus Budget Reconciliation Act of 1990.

- A. Full semi-private room, or an allowance of the hospital's most prevalent semi-private rate toward a private room. (Private room is covered in full if medically necessary.)
B. All other care in the nature of usual hospital services.
C. Maternity care, usual and customary care for all female recipients.

The benefits of this program do not extend to:

Any services or supplies provided, on or after November 1, 1988, to a hospital inpatient by practitioners, providers, or suppliers, regardless of where the services are provided, after total benefit expenditures related to the hospitalization(s) under the Texas Medical Assistance Program, per recipient per 12-month benefit period, reach \$200,000. This limit does not apply to services provided to hospital inpatients by individuals licensed to practice medicine or osteopathy at the time and place the services are provided. This limit does not apply to medically necessary services provided to an inpatient less than age 21 in compliance with the EPSDT provisions of the Omnibus Budget Reconciliation Act of 1989 and the provisions of Section 4604 of the Omnibus Budget Reconciliation Act of 1990. For purposes of this limit, a 12-month benefit period is defined as the 12 consecutive months period beginning November 1 and ending October 31 each year. This limit will apply to hospitalization related services, while a recipient is a hospital inpatient, irrespective of when it is reached in the 12-month benefit period and irrespective of whether one or more inpatient hospital stays, per recipient, are involved. For purposes of this limit, the state agency or its designee will process claims and pay, if payable, on the basis of the first claim received by the agent.

Handwritten form with fields for STATE (Texas), DATE (9-30-98), DATE (9-14-98), DATE (9-1-97), DATE (97-10), and a box containing the letter A.

SUPERSEDES: TN - 91-27

2.a. Outpatient Hospital Services.

These shall include diagnostic, therapeutic, rehabilitative or palliative items or services furnished by or under the direction of a physician except that no payment will be made for: (1) drugs and biologicals which can be self-administered; (2) occupational therapy that is not medically prescribed treatment designed to improve or restore an individual's ability to perform those tasks required for independent functioning in the self-care activities of eating, personal hygiene, dressing and communication.

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DATE APP'VD	JAN 18 1988	
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TN No. 88-21  
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2.b. Rural Health Clinic Services.

The specifications, conditions and limitations established by the single state agency for coverage of services provided by a rural health clinic under the Texas Medical Assistance Program are as follows:

- A. As a condition for receiving payment for rural health clinic services as defined at 42 CFR 440.20 (b), the services must be medically necessary and be provided to an eligible recipient by a certified and approved rural health clinic in accordance with applicable Federal, State and local laws and regulations.
- B. As a condition for receiving payment for other ambulatory services which are covered under this State Plan and which are apart from and other than rural health clinic services as defined at 42 CFR 440.20 (c), a rural health clinic, as the provider, must meet the same conditions of participation as any other provider of the same services(s) and is subject to the qualifications, limitations, and exclusions in the amount, duration and scope of benefits and all other provisions specified in this State Plan and elsewhere.
- C. The rural health clinic must contract with the single state agency.
- D. The rural health clinic must provide reports and other information specified by the single state agency or its authorized representative.
- E. Rural health clinic personnel providing primary health care must be licensed in Texas or in the State within the United States in which and at the time and place the service(s) is provided and/or meet all other established qualifications.
- F. Any covered service furnished to an eligible recipient in a long term care facility must be ordered by the recipient's treating physician. A physician is defined as a M.D. or D.O.
- G. The rural health clinic must be certified and participate under Title XVIII of the Social Security Act.
- H. The plan of treatment to be used for visiting nurse services must be developed by the rural health clinic physician and be approved and ordered by the recipient's treating physician.

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2.c. Federally Qualified Health Center Services.

(a) Effective for services on or after April 1, 1990, and subject to the specifications, conditions, limitations, and requirements established by the state agency, Federally Qualified Health Center (FQHC) services are available to eligible Medicaid recipients.

(b) Covered services are limited to:

(1) services as described in 1861(aa)(1)(A)-(C) of the Social Security Act, and are medically necessary. These services include:

- (A) physician services;
- (B) physician assistant services;
- (C) nurse practitioner services;
- (D) clinical psychologist services;
- (E) clinical social worker services;
- (F) services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services; and

(G) visiting nurse services to a homebound individual, in the case of those FQHCs that are located in an area that has a shortage of home health agencies as determined by the state survey agency.

(2) other ambulatory services which are covered by the Texas Medical Assistance program when provided by other enrolled providers.

(c) Covered services provided by an FQHC must be reasonable and medically necessary as determined by the state agency.

(d) To participate in the Texas Medical Assistance Program, a Federally Qualified Health Center (FQHC) must meet the following requirements:

(1) be receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or be designated by the Secretary of the Department of Health and Human Services as meeting the requirements to be receiving such a grant;

(2) comply with all federal, state, and local laws and regulations applicable to the services provided;

(3) be enrolled and approved for participation in the Texas Medical Assistance program.

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3. Other Laboratory and X-Ray Services.

Laboratory Services provided by an approved laboratory.

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4.a. Nursing Facility Services for Individuals 21 Years of Age or Older.

Nursing facility services (other than services in an institution for tuberculosis or mental disease) provided in a Title XIX nursing facility approved by the single state agency to eligible individuals are limited by a requirement for a medical necessity determination. The treating physician prescribes the nursing facility setting and the state agency provides the medical necessity determination for which payment will be made.

Nursing facility services includes drugs that are reimbursed through the Vendor Drug Program. This encompasses all drugs contained in the resident's plan of care, subject to the drug rebate provision of Section 4401 of the Omnibus Budget Reconciliation Act of 1990.

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4.b. EPSDT Services.

EPSDT prior authorization requirement: Prior authorization is required for payment of dental services in excess of the ceiling amount established for initial services or if subsequent appointments and services are required. Also, prior authorization is required for hospitalization expenses in connection with dental services. An orthodontic plan of treatment must be received, authorized and prepaid while the client is Medicaid-eligible and under 21 years of age. Provider reimbursement to complete the prior authorized prepaid orthodontic plan of treatment may be continued for clients losing EPSDT or Medicaid eligibility.

Eligible medical assistance recipients covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program are entitled to optometric and eyeglass services as described below and elsewhere in this State Plan, when provided by a physician, optometrist, or optician enrolled in the Texas Medical Assistance Program at the time the service(s) is provided.

Each EPSDT recipient is entitled to one eye exam by refraction each state fiscal year (September 1st through August 31st), whether performed by a Doctor of Optometry or a physician (M.D. or D.O.), unless the need for additional medically necessary refractions is discovered during the screening process. This limit of one eye refraction per recipient, per state fiscal year, applies to both prosthetic (aphakic) eyewear and non-prosthetic eyewear. This limit does not apply to other diagnostic and/or treatment of the eye for medical conditions, other than determination of visual acuity. Diagnostic and treatment services provided by an optometrist are covered by the Texas Medical Assistance Program if the services are (1) within the optometrist's scope of practice, as defined by state law and (2) reasonable and medically necessary as determined by the single state agency or its designee. Other diagnostic and treatment services provided by a physician are described elsewhere in this State Plan.

Prosthetic eyewear, including contact lenses and glass or plastic lenses in frames, is a program benefit provided to an eligible recipient if the eyewear is prescribed for post cataract surgery, congenital absence of the eye lens, or loss of an eye lens because of trauma. Reimbursement is made for as many temporary lenses as are medically necessary during post surgical cataract convalescence (the four-month period following the date of cataract surgery). One pair of permanent prosthetic lenses can be dispensed as a program benefit. However, reimbursement is made by the program for the repair or replacement of lost or destroyed prosthetic eyewear and the replacement of prosthetic eyewear when it is required because of a change in visual acuity of .5 diopter or more.

Payment is not authorized for eyewear with little or no chance for correction of refraction errors. In addition, payment is limited to zylonite eyeglass frames and the basic serviceable types of lenses and style of frames which meet specifications established by the single state agency.

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4.b EPSDT Services (Continued)

Repairs to prosthetic eyewear are reimbursable if the cost of materials exceeds \$2. Repairs costing less than \$2 are not reimbursable by the program and the provider may not bill the recipient for these services.

Nonprosthetic eyewear is available only once every 24 months, unless a recipient's eyes undergo a change in visual acuity of .5 diopters or more, or the eyewear is lost or destroyed. Provisions have been made for the necessary repair or replacement of lost or destroyed nonprosthetic eyewear.

Optometric services provided in skilled or intermediate care facilities are reimbursable by the program if the recipient's attending physician has ordered the services(s) and the order is included in the recipient's medical records at the nursing facility.

EPSDT Expansion under OBRA of 1989 - The single state agency will provide other health care described in Section 1905(a) of the Social Security Act that is found to be medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the EPSDT screen, even when such health care is not otherwise covered under the State Plan.

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4.b. EPSDT Services (Continued)

Rehabilitative Chemical Dependency Treatment Facility  
Services.

(a) Subject to the specifications, conditions, limitations, and requirements established by the single state agency, rehabilitative chemical dependency treatment facility services are those facility services recommended by a physician or other licensed practitioner within the scope of his practice under state law and determined to be reasonable and necessary for the care of a person under 21 years of age who is chemically dependent.

(b) "Chemical dependency" is defined as meeting at least three of the Diagnostic Criteria for Psychoactive Substance Dependence in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

(c) Covered rehabilitative chemical dependency treatment facility services include:

- (1) Outpatient individual counseling services, and
- (2) Outpatient group counseling services.

(d) Covered rehabilitative chemical dependency treatment facility services are limited as follows:

- (1) Outpatient individual chemical dependency treatment counseling services are limited to a maximum of 26 hours per person per calendar year\*, and
- (2) Outpatient group chemical dependency treatment counseling services are limited to a maximum of 135 hours per person per calendar year.\*

(e) A chemical dependency treatment facility must:

- (1) Be a facility that is licensed by the Texas Commission on Alcohol and Drug Abuse (TCADA), the state licensure authority, as a chemical dependency treatment facility;
- (2) Provide, at a minimum, the standard services required by TCADA for licensure (as determined by the type of chemical dependency service(s) it provides);
- (3) Comply with all applicable federal, state, and local laws and regulations;
- (4) Be enrolled and approved for participation in the Texas Medical Assistance Program;

\* Durational, dollar, and quantity limits are waived for recipients of EPSDT services. Services allowable under Medicaid laws and regulations may be covered when medically necessary for these recipients.

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